STATE OF WASHINGTON

DEPARTMENT OF HEALTH

OFFICE OF NEWBORN SCREENING

1610 N.E. 150th Street • Shoreline, WA 98155-9701

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AUTHORIZATION TO DISCLOSE NEWBORN SICKLE CELL SCREENING RESULTS

I,_____, do hereby authorize the Washington State Department of Health Newborn Screening Program to disclose the results of newborn sickle cell (hemoglobin) screening for the individual identified in Section 1 below to the individual or institution identified in Section 2 below. This authorization is limited to the disclosure of the results of newborn sickle cell (hemoglobin) screening for this single purpose and expires thereafter.

1. Individual whose newborn sickle cell screening results are to be released:

Name: _____

Date of Birth: _____

Place of Birth: _____
(Hospital or facility name) (City)

Mother's Name: _____
(At time of birth)

2. Individual or Institution to whom results are to be released:

Name of Institution: _____

Athletic Department Contact:_____Email: _____

Address: _____

City, State, and Zip Code: _____

Contact phone: _____ Fax: _____

**********Requester Information**********

Signature: _____ Date: _____

Name: _____Relationship to patient: _____

Address: _____

City, State, and Zip Code:_____Contact phone: _____